The James L. Dennis Developmental Center
1301 Wolfe Street
Little Rock, Arkansas 72202

Clinic Telephone Number: (501) 364-1830
Fax: (501) 364-4967

INTAKE REQUEST (Part 2: Parent/Guardian)

Date of Request _____

PATIENT NAME _____
Last First Middle

Patient Date of Birth:	**Age:**	**Sex:**	**Race:**
Patient Street Address:			
Patient Town/City:	**Zip Code:**	**County:**	
Home Telephone: (Include Area Code)	**Cell Phone:**		
Best phone number to contact you Mon-Fri between 9A and 3P:			
Parents or Legal Guardian of Patient:			
Work Telephone:	**Message Telephone:**		
Primary Care Physician (PCP):			
PCP Telephone:	**PCP Office location (town):**		
School Child Attends:	**Grade:**		
What is the primary language spoken in the home?			

Is this appointment a first time visit or a follow up visit to the DDC?
_____ First Time Visit
_____ Follow-up Visit (___For Medical ___For Testing)

PLEASE NOTE**:* The ***Dennis Developmental Center specializes in the assessment of developmental conditions that result in delayed milestones, inability to communicate effectively, inattention, hyperactivity, impulsivity, learning problems, and poor or atypical social interactions. Evaluation and therapy are also provided for families coping with the stress of chronic developmental disorders or chronic medical illnesses, and with grief and loss concerns. ***Please refer your patient to the Child and Adolescent Psychiatric Division (Child Study Center at 501-364-5150) at Arkansas Children's Hospital or your local mental health agency*** *for diagnosis or treatment of disorders that are primarily psychiatric (i.e., bipolar disorder, anxiety disorders, oppositional defiant disorder, conduct disorder, personality disorders, etc.) or issues related to child abuse or custody.*

What do you think are your child's main problems?_____

_____

_____

_____

_____

What have you been told by doctors, teachers, or others about your child's problems?_____

_____

_____

What questions do you want answered from your child's Dennis Developmental Center evaluation?

_____

_____

Has your child ever had testing to evaluate for learning or developmental problems?
____No ____Yes

If yes, when was testing done? **Where was testing done?**

Please indicate any services your child currently receives:

____Early Childhood Developmental Services
____Self-Contained Classes
____Resource (i.e., special education) Classes
____Speech/Language Therapy
____Occupational Therapy
____Physical Therapy
____Title I
____Counseling
____504 Modifications
____ Other:_____

Serious illnesses or major medical problems? ____No ____Yes **please list problems:**

Vision Problems? ____No ____Yes **Hearing Problems?** ____No ____Yes

Has the child previously received mental health diagnosis or treatment? ____No ____Yes **please list:**

Does this child take any medications on a regular basis? ____No ____Yes **please list:**

***Comments*: Is there anything else you would like us to know about the child?**

Form completed by: _____